A CLOSER LOOK AT PARTIAL-BIRTH ABORTIONS

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OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES

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Mr. DORNAN. Mr. Speaker, even liberal newspapers such as the Washington Post agree that abortion advocates have been fast and loose with the facts concerning H.R. 1833, the Partial-Birth Abortion Act. It's time to set the record straight. Here is an in-depth, factual analysis of this important, life-saving bill.

[From the National Right to Life Committee, Inc., Sept. 11, 1996]

PARTIAL-BIRTH ABORTIONS: A CLOSER LOOK

(By Douglas Johnson, NRLC Federal Legislative Director)

The final version of the Partial-Birth Abortion Ban Act (HR 1833) was approved by the U.S. Senate by a vote of 54–44 on December 7, 1995, and by the U.S. House of Representatives on March 27, 1996, by a vote of 286–129. On April 10, 1996, President Clinton vetoed the bill. The House is expected to vote on whether to override the veto on or about September 19, 1996. If two-thirds of the House votes to override, the Senate also will vote on whether to override.

Opponents of the bill, including President Clinton and his subordinates, have propagated a number of myths regarding the partial-birth abortion procedure and the bill. These myths include the assertions that partial-birth abortions are very rare and are performed only in extreme circumstances involving serious fetal deformities or threat to the life of the mother; that the bill would jeopardize the lives or health of some women; and that anesthesia given to the mother kills the fetus/baby or renders her pain-free before the procedure is performed. Some of this misinformation—especially the claim that the procedure is used mostly in cases of severe ''fetal deformity''—has been uncritically adopted as factual by some journalists, columnists, and editorialists.

Yet, these claims are contradicted by the past writings and recorded statements of doctors who have performed thousands of partial-birth abortions, and by other available documentation, including authoritative medical information gathered by the House Judiciary Committee and the Senate Judiciary Committee. This factsheet relies heavily upon such primary sources. For copies of documents cited here, contact the NRLC Federal Legislative Office at (202) 626–8820, fax (202) 347–3668.

WHAT IS A PARTIAL-BIRTH ABORTION, AND WHAT IS THE PARTIAL-BIRTH ABORTION BAN ACT (HR 1833)?

The Partial-Birth Abortion Ban Act (HR 1833) would prohibit performance of a partial-birth abortion, except in cases (if there are many) in which the procedure is necessary to save the life of a mother. The complete text of the bill is attached to this factsheet.

The bill defines a ''partial-birth abortion'' as ''an abortion in which the person performing the abortion partially vaginally delivers a long fetus before killing the fetus and completing the delivery.'' Abortionists who violates the law would be subject to both criminal and civil penalties, but no penalty would be applied to the woman who obtained such an abortion.

This procedure is generally beginning at 20 weeks (4½ months) in pregnacy, and ''routinely'' at least 24 weeks (5½ months). It has often used much later—even into the ninth month. The Los Angeles Times accurately and succinctly described this abortion method in a June 16, 1995 news story: The procedure requires a physician to extract a fetus, feet first, from the womb and through the birth canal until all but its head is exposed. Then the tips of surgical scissors are thrust into the base of the fetus' skull, and a suction catheter is inserted through the opening and the brain is removed.

In 1992, Dr. Martin Haskell of Dayton, Ohio, wrote a paper that described in detail, step-by-step, how to preform the procedure. [''Dilation and Extraction for Late Second Trimester Abortion.''] Dr. Haskell is a family practitioner who has performed over 1,000 such procedures in his walk-in abortion clinics. Anyone who is seriously seeking the truth behind the conflicting claims regarding partial-birth abortions would do well to start by reading Dr. Haskell's paper, and the transcripts of the explanatory interviews that Dr. Haskell gave in 1993 to two medical publications, American Medical News (the official AMA newspaper) and Cincinnati Medicine. [All are available from NRLC.]

Here is how Dr. Haskell explained a key part of the abortion method: With a lower [fetal] extremity in the vagina, the surgeon uses his fingers to deliver the opposite lower extremity, then the torso, the shoulders and upper extremities. The skull lodges at the internal cervical os[the opening to the uterus]. Usually there is not enough dilation for it to pass through. The fetus is oriented dorsum or spineup. At this point, the right-handed surgeon slides the fingers of the left hand along the back of the fetus and ''hooks the shoulders of the fetus with the index and ring fingers (palm down) * * * [T]he surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger * * * [T]he surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents.'' [''Dilation and Extraction for Late Second Trimester abortion,'' pages 30–31.]

Dr. Haskell also wrote that he ''routinely performs this procedure on all patients 20 through 24 weeks LMP [i.e., from 4½ to 5½ months after the last menstrual period] with certain exceptions,'' these ''exceptions'' involving complicating factors such as being more than 20 pounds overweight. Dr. Haskell also wrote that he used the procedure through 26 weeks [six months] ''on selected patients.'' [p.28] He added, ''Among its advantages are that it is a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.'' (p. 33).

In sworn testimony in an Ohio lawsuit on Nov. 8, 1995, Dr. Haskell explained that he first learned of the method when a colleague described very briefly over the phone to me a technique that I later learned came from Dr. [James] McMahon where they internally grab the fetus and rotate it and accomplish—be somewhat equivalent to a breech type of delivery.

Dr. James McMahon, who died in 1995, used essentially the same procedure thousands of times, and to a much later point in pregnancy—even into the ninth month. Other abortionists also employ the procedure, as discussed below.

AREN'T ''THIRD TRIMESTER'' ABORTIONS RARE? AT WHAT STAGE IN PREGNANCY DO PARTIAL-BIRTH ABORTIONS OCCUR? ARE THESE BABIES ''VIABLE''?

It appears that the substantial majority of partial-birth abortions are performed late in the second trimester—that is, before the 27-week mark—but usually after 20 weeks (4½ months). There is compelling evidence that the overwhelming majority of these pre-week-27 partial-birth abortions are performed for purely ''social'' reasons.

In an attempt to ''filter out'' this documentation, many opponents of the bill attempt to narrow the debate to only third-trimester partial-birth abortions procedures—that is, to abortions performed beginning in the 27th week [seventh month] of pregnancy. Some journalists and commentators have readily adopted this ''filter.'' However, there is really no non-ideological justification for adopting this ''third trimester'' demarcation. It has no basis in the text of the Partial-Birth Abortion Ban Act (HR 1833), which bans partial-birth abortion at any point in pregnancy. Nor, contrary to some popular misconceptions, is there any basis in current Supreme Court constitutional doctrine or in neo-natal medical practice for adopting a ''third trimester'' demarcation.

Under the Supreme Court's doctrine, ''viability'' is regarded as the constitutionally significant demarcation. In Planned Parenthood v. Casey (1992), the Supreme Court explicitly disavowed the ''trimester framework'' of Roe v. Wade (1973), and reaffirmed that ''viability'' is (in the Court's view) the constitutionally significant demarcation. ''Viability'' is the point at which a baby born prematurely can be sustained by good medical assistance. Currently, many babies are ''viable'' a full three weeks before the ''third trimester.'' Therefore, most partial-birth abortions kill babies who are already ''viable,'' or who are at most a few days or weeks short of viability.[1]

(Even at 20 weeks, the baby is seven inches long on average. And, as discussed below, at a March 21 congressional hearing leading medical authorities testified that the baby by this point is very sensitive to painful stimuli.)

At least one partial-birth abortion specialist, the late Dr. James McMahon, regularly performed the procedure even after 26 weeks—even into the ninth month. In 1995, Dr. McMahon submitted to the House Judiciary Constitution Subcommittee a graph and explanation that explicitly showed that he aborted healthy (''not flawed'') babies even in the third trimester (after 26 weeks of pregnancy). Dr. McMahon's own graph showed, for example, that at 29 or 30 weeks, one-fourth of the aborted babies had no ''flaw'' however slight. Underneath the graph, Dr. McMahon offered this explanation: After 26 weeks, those pregnancies that are not flawed are still non-elective. They are interrupted because of maternal risk, rape, incest, psychiatric or pediatric indications. [chart and caption reproduced in June 15 hearing record, page 109]

In an interview with Constitution Subcommittee Counsel Keri Harrison, Dr. McMahon explained that ''pediatric indication'' referred to underage mothers, not to any medical condition of the mother or the baby.

[1] According to the landmark survey of neonatal units in the National Institute of Child Health and Human Development Neonatal Research Network, conducted in 1987 and 1988 by Dr. Maureen Heck, et al, babies born at 23 weeks had on average a 23% chance of survival, rising to 34% at 24 weeks, and 54% at 25 weeks. See ''Very Low Birth Weight Outcomes of the National Institute of Child Health and Human Development Neonatal Network,'' Pediatrics, May 1991.

IS THE BABY ALIVE WHEN SHE IS PULLED FEET-FIRST FROM THE WOMB?

American Medical News reported in 1993, after conducting interviews with Drs. Haskell and McMahon, that the doctors ''told AM News that the majority of fetuses aborted this way are alive until the end of the procedure.'' On July 11, 1995, American Medical News submitted the transcript of the tape-recorded interview with Dr. Haskell to the House Judiciary Committee. The transcript contains the following exchange:

American Medical News: Let's talk first about whether or not the fetus is dead beforehand.

Dr. Haskell: No it's not. No, it's really not. A percentage are for various numbers of reasons. Some just because of the stress—intrauterine stress during, you know, the two days that the cervix is being dilated [to permit extraction of the fetus]. Sometimes the membranes rupture and it takes a very small superficial infection to kill a fetus in utero when the membranes are broken. And so in my case, I would think probably about a third of those are definitely are [sic] dead before I actually start to remove the fetus. And probably the other two-thirds are not.

In an interview quoted in the Dec. 10, 1989 Dayton News, Dr. Haskell conveyed that the scissors thrust is usually the lethal act: ''When I do the instrumentation on the skull * * * it destroys the brain tissue sufficiently so that even if it (the fetus) falls out at that point, it's definitely not alive,'' Dr. Haskell said. [For further evidence on this issue, see the next section.]

Brenda Pratt Shafer, a registered nurse from Dayton, Ohio, stood at Dr. Haskell's side while he performed three partial-birth abortions in 1993. In testimony before the Senate Judiciary Committee (Nov. 17, 1995), Shafer described in detail the first of the three procedures—which involved, she said, a baby boy at 26½ weeks (over 6 months). According to Mrs. Shafer, the baby was alive and moving as the abortionist delivered the baby's body and the arms—everything but the head. The doctor kept the baby's head just inside the uterus. The baby's little fingers were clasping and unclasping, and his feet were kicking. Then the doctor stuck the scissors through the back of his head, and the baby's arms jerked out in a flinch, a startle reaction, like a baby does when he thinks that he might fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening and sucked the baby's brains out. Now the baby was completely limp.

Under HR 1833, in any case in which a baby dies before being partly removed from the uterus—whether of natural causes or by an action of an abortionist—the subsequent removal of that baby is not a partial-birth abortion as defined by the bill.

DOES ANESTHESIA GIVEN TO THE MOTHER KILL THE BABY?

Many prominent defenders of partial-birth abortion have publicly insisted that the unborn babies are killed by anesthesia given to the mother, prior to being ''extracted'' from the womb. For example, syndicated columnist Ellen Goodman wrote in November, 1995, that if you listened to supports of the ban, ''You wouldn't even know that anesthesia ends the life of such a fetus before it comes down the birth canal.'' NARAL President Kate Michelman said, ''The fetus, is, before the procedure begins, the anesthesia that they give the woman already causes the demise of the fetus. That is, it is not true that they're born partially. That is a gross distortion, and it's really a disservice to the public to say this.'' [KMOX–AM, St. Louis, Nov. 2, 1995]

Likewise, Planned Parenthood distributed to Congress a ''fact sheet'' signed by Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington, which stated, ''The fetus dies of an overdose of anesthesia given to the mother intravenously * * * This induces brain death in a fetus in a matter of minutes. Fetal demise therefore occurs at the beginning of the procedure while the fetus is still in the womb.''

However, when this statement was read to Dr. Norig Ellison, the president of the 34,000-member American Society of Anesthesiologists (ASA), he testified, ''There is absolutely no basis in scientific fact for that statement * * * think the suggestion that the anesthesia given to the mother, be it regional or general, is going to cause brain death of fetus is without basis fact.'' [Senate Judiciary Committee hearing record J–104–54, Nov. 17, 1995, p. 153]

Subsequently, in attempting to defend their ''fetal demise'' claims, pro-abortion advocacy groups disseminated new claims that the late Dr. James McMahon had utilized exceptionally massive doses of narcotic anesthesia before performing his abortions, and that these massive doses would indeed kill a fetus. But in the testimony before the House Judiciary Constitution Subcommittee on March 21, 1996, Dr. David J. Birnbach, president-elect of the Society for Obstetric Anesthesia and Perinatology, testified: In order to cause fetal demise, it would be necessary to give the mother dangerous and life-threatening doses of anesthesia.'' [* * *] Although there is no evidence that this massive dose will cause fetal demise, there is clear evidence that this excessive dose could cause maternal death. [House Judiciary Committee hearing record no. 73, pages 140, 142]

SINCE THE BABY IS STILL ALIVE WHEN ''EXTRACTED'' FROM THE WOMB, DOES SHE FEEL PAIN?

Dr. Norig Ellison, president of the American Society of Anesthesiologists (ASA), wrote to the Senate Judiciary Committee: Drugs administered to the mother, either local anesthesia administered in the paracervical area or sedatives/analgesics administered intramuscularly or intravenously, will provide little-to-no analgesia [pain relief] to the fetus. [Senate Judiciary Committee, Nov. 17, 1995 hearing record, page 226]

On March 21, 1996, the House Judiciary Subcommittee on the Constitution conducted a public hearing on ''The Effects of Anesthesia During a Partial-Birth Abortion.'' Four leading experts in the field testified that the fetuses/babies who are old enough to be ''candidates'' for partial-birth abortion possess the neurological equipment to respond to painful stimuli, whether or not the mother has been anesthetized. Opponents of the bill were unable to produce a single medical witness willing to testify in support of the claims that anesthesia kills the fetus or renders the fetus insensible to pain. [See House Judiciary Committee Hearing Record No. 73, March 21, 1996.)

Dr. Jean A. Wright, associate professor of pediatrics and anesthesia at the Emory University School of Medicine in Atlanta, testified that recent research shows that by the stage of development that a fetus could be a ''candidate'' for a partial-birth abortion (20 weeks), the fetus ''is more sensitive to pain than a full-term infant would be if subjected to the same procedures,'' Prof. Wright testified. These fetuses have ''the anatomical and functional processes responsible for the perception of pain,'' and have ''a much higher density of Opioid (pain) receptors'' than older humans, she said.

Dr. David Birnbach, president-elect of the Society for Obstetric Anesthesia and Perinatology, testified, ''Having administered anesthesia for fetal surgery, I know that on occasion we need to administer anesthesia directly to the fetus because even at these early ages the fetus moves away from the pain of the stimulation.'' [hearing record, page 288]

At a hearing before the same panel on June 15, 1995, Professor Robert White, Director of the Division of Neurosurgery and Brain Research Laboratory at Case Western Reserve School of Medicine, testified, ''The fetus within this time frame of gestation, 20 weeks and beyond, is fully capable of experiencing pain.'' After analyzing the partial-birth procedure step-by-step for the subcommittee, Prof. White concluded: ''Without question, all of this is a dreadfully painful experience for any infant subjected to such a surgical procedure.'' [House Judiciary Committee hearing No. 31, June 15, 1995, page 70.] Prof. Jean Wright concluded, ''This procedure, if it were done on an animal in my institution, would not make it through the institutional review process. The animal would be more protected than this child is.'' [hearing record, page 286]

DOES THE BILL CONTAIN AN EXCEPTION FOR LIFE-OF-THE-MOTHER CASES?

HR 1833 explicitly provides that the ban ''shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury,'' if ''no other medical procedure would suffice for that purpose.''

[Some pro-abortion advocacy groups have insisted that exception does not apply to disorders associated with pregnancy, since ''pregnancy'' per se is not a disorder or disease. House Judiciary Committee Chairman Henry J. Hyde (R–11.) commented that this reading ''is absurdly convoluted, and violates standard principles of statutory construction.'' In a June 7 letter, even President Clinton has acknowledged that the bill ''provides an exception to the ban on this procedure only when a doctor is convinced that a woman's life is at risk.'']

Under HR 1833, an abortionist could not be convicted of a violation of the law unless the government proved, beyond a reasonable doubt, that the abortion was not covered by this exception. (In addition, of course, the government would have to prove, beyond a reasonable doubt, all of the other elements of the offense—that the abortionist ''knowingly'' partly removed a baby from the womb, that the baby was still alive, and that the abortionist then killed the baby.)

It is noteworthy that none of the five women who appeared with President Clinton at his April 10 veto ceremony required a partial-birth abortion because of danger to her life. As one of the women, Claudia Crown Ades, said in a tape-recorded April 12 radio interview on WNTM (Mobile, AL): ''My procedure was elective. That is considered an elective procedure, as were the procedures of Coreen Costello and Tammy Watts and Mary-Dorothy Line and all the other women who were at the White House yesterday. All of our procedures were considered elective.'' [Complete tape recording available on request.]

[Two of the women said that if their babies had died natural deaths within their wombs, it could have placed them at risk. But the removal of a baby who dies a natural death, whether by foot-first extraction or in any other manner, is not an abortion and has nothing to do with the bill. Professor Watson Bowes, Jr., of the University of North Carolina, co-editor of the Obstetrical and Gynecological Survey, has stated that weeks would pass between the baby's natural demise and the development of any resulting risk to the mother.]

WHAT REASONS HAS PRESIDENT CLINTON GIVEN FOR VETOING HR 1833?

On December 7, 1995, before the Senate had even voted on final passage of the bill, chief opponent Sen. Barbara Boxer (D-Cal.) took the floor to make an unqualified statement that President Clinton would veto the bill. On December 8, White House Press Secretary Michael McCurry said unequivocally that the President would veto the bill because ''it would represent an erosion of a woman's right to choose.''

However, when President Clinton next publicly addressed the issue in a February 28 letter to key members of Congress (after a national poll found 71% support for the ban), he took different tone, although the legal bottom line was unchanged. Mr. Clinton wrote of having ''studied and prayed about this issue * * * for many months,'' of finding the procedure ''very disturbing,'' and of seeking ''common ground * * * that respects the views of those—including myself—who object to this particular procedure,'' while defending Roe v. Wade. But the ''common ground'' that Mr. Clinton proposed tracked the language offered by Sen. Boxer on December 7, and endorsed by the National Abortion and Reproductive Rights Action League (NARAL) as a ''pro-choice vote.'' The Boxer/NARAL amendment would have allowed partial-birth abortion to be performed without any limitation whatever until ''viability,'' and also ''after viability where, in the medical judgment of the attending physician, the abortion is necessary to preserve the life of the woman or avert serious adverse health consequences to the woman.'' (The Senate rejected this gutting amendment.)

The Boxer/Clinton language must be read in the light of Doe v. Bolton, the 1973 companion case to Roe v. Wade, in which the Supreme Court said that ''health'' must encompass ''all factors—physical, emotional, psychological, familial and the woman's age—relevant to the well-being of the patient.'' Given this expansive definition of ''health,'' adding the word ''serious'' has no legal effect, since Mr. Clinton proposes to leave entirely up to each abortionist to decide whether ''depression'' or some other ''health'' concern is ''serious.''

In a June 7 letter to leaders of the Southern Baptist Convention, Mr. Clinton said that he favored banning the procedure with an exception for ''cases where a woman risks death or serious damage to her health,'' but not for cases involving ''youth'' or ''emotional stress.'' But in his formal veto message on the bill, Mr. Clinton referred to a ''health'' exception as required by Roe v. Wade. Mr. Clinton, a former teacher of constitutional law, knows full well that these two positions are inconsistent, because if Roe/Doe applies to partial-birth abortions, then even after ''viability,'' the exception must indeed cover ''emotional'' health.

In his June 7 letter, President Clinton asserted that ''the medical community * * * broadly supports the continued availability of this procedure where a woman's serious health interests are at stake.'' However, the American Medical Association (AMA) Legislative Council voted unanimously to recommend endorsement of the bill, with one member explaining that the procedure was ''not a recognized medical technique.'' (The full AMA Board of Trustees was divided on the bill and ultimately took ''no position.'') Of the five medical doctors who serve in Congress, four voted for the bill, including the only family practitioner/gynecologist.

HOW OFTEN ARE PARTIAL-BIRTH ABORTIONS PERFORMED?

There are at least 164,000 abortions a year after the first three months of pregnancy, and 13,000 abortions annually after 4½ months, according to the Alan Guttmacher Institute (New York Times, July 5 and November 6, 1995), which is an arm of Planned Parenthood. These numbers should be regarded as minimums, since they are based on voluntary reporting to the AGI. (The Centers for Disease Control reported that in 1993, over 17,000 abortions were performed at 21 weeks and later—and the CDC acknowledges that the reports that it receives are incomplete.)

No one really knows how many late abortions are done by the partial-birth procedure. The Center for Reproductive Law and Policy told The New York Times, ''The number of procedures that clearly meet the definition of partial birth abortion is very small, probably only 500 to 1,000 a year.'' (March 28, 1996) Even if such figures were accurate, the legislation would be urgently needed. If a new virus swept through neo-natal units and killed 500 or 1,000 premature babies, it would be a top news story—not dismissed as too ''rare'' to be of consequence. For each human being at the pointed end of the scissors, a partial-birth abortion is a 100% proposition.

Moreover, the numbers may be considerably higher—perhaps thousands per year. Dr. Martin Haskell and the late Dr. James McMahon spend years trying to convince other abortionists of the merits of the procedure—that was the purpose of Dr. Haskell's 1992 instructional paper (see page 3) which was distributed by the National Abortion Federation, a lobbying group for abortion clinics. For years, Dr. McMahon was director of abortion instruction at the Cedar-Sinai Medical Center in Los Angeles. In addition, he invited other doctors to visit his abortion clinic for a period of days to learn the procedure. Also, The New York Times reported on Nov. 6, 1995: ''Of course I use it, and I've taught it for the last 10 years,'' said a gynecologist at a New York teaching hospital who spoke on condition of anonymity. ''So do doctors in other cities.''

It is not known how many other abortionists have adopted the method, but a few have made themselves known. On March 19, 1996, Dr. William Rashbaum of New York City wrote a letter to Congressman Charles Canady (R–FL), stating that he has performed 19,000 late-term ''procedures,'' and that he has performed the procedure that HR 1833 would ban ''routinely since 1979. This procedure is only performed in cases of later gestational age.''

In 1995, Dr. Martin Haskell filed a lawsuit challenging a state abortion-regulation law. In that proceeding, two other doctors filed affidavits affirming that they perform the same procedure as Dr. Haskell—and that's just in Ohio.

FOR WHAT REASONS ARE LATE-TERM ABORTIONS USUALLY PERFORMED?

There is no evidence that the reasons for which late-term abortions are performed by the partial-birth abortion method are any different, in general, than the reasons for which late-term abortions are performed by other methods—and it is well established that the great majority of late-term abortions do not involve any illness of the mother or the baby. They are purely ''elective'' procedures—that is, they are performed for purely ''social'' reasons.

In 1987, the Alan Guttmacher Institute (AGI), an affiliate of the Planned Parenthood Federation of America (PPFA), collected questionnaires from 1,900 women who were at abortion clinics procuring abortions. Of the 1,900, ''420 had been pregnant for 16 or more weeks.'' These 420 women were asked to choose among a menu of reasons why they had not obtained the abortions earlier in their pregnancies. Only two percent (2%) said ''a fetal problem was diagnosed late in pregnancy,'' compared to 71% who responded ''did not recognize that she was pregnant or misjudged gestation,'' 48% who said ''found it hard to make arrangements,'' and 33% who said ''was afraid to tell her partner or parents.'' The report did not indicate that any of the 420 late abortions were performed because of maternal health problems. [''Why Do Women Have Abortions?,'' Family Planning Perspectives, July/August 1988.]

Also illuminating is an 1993 internal memo by Barbara Radford, then the executive director of the National Abortion Federation, a ''trade association'' for abortion clinics: There are many reasons why women have late abortions: life endangerment, fetal indications, lack of money or health insurance, social-psychological crises, lack of knowledge about human reproduction, etc.''

Likewise, a June 12, 1995, National Abortion Federation letter to members of the House of Representatives noted that late abortions are sought by, among others, ''very young teenagers * * * who have not recognized the signs of their pregnancies until too late,'' and by ''women in poverty, who have tried desperately to act responsibly and to end an unplanned pregnancy in the early stages, only to face insurmountable financial barriers.''

In her article about late-term abortions, based in part on extensive interviews with Dr. McMahon and on direct observation of his practice (Los Angeles Times Magazine, January 7, 1990), reporter Karen Tumulty concluded: If there is any other single factor that inflates the number of late abortions, it is youth. Often, teen-agers do not recognize the first signs of pregnancy. Just as frequently, they put off telling anyone as long as they can.

According to Peggy Jarman, spokeswoman for Dr. George Tiller, who specializes in late-term abortions in Wichita, Kansas: About three-fourths of Tiller's late-term patients, Jarman said, are teen-agers who have denied to themselves or their families they were pregnant until it was too late to hide it. [Kansas City Star]

FOR WHAT REASONS ARE PARTIAL-BIRTH ABORTIONS USUALLY PERFORMED?

Some opponents of HR 1833, such as NARAL and the Planned Parenthood Federation of America (PPFA), have persistently disseminated claims that the partial-birth abortion procedure is employed only in cases involving extraordinary threats to the mother or grave fetal disorders. For example, NARAL President Kate Michelman wrote in a Scripps Howard News Service op ed published June 16, 1996, ''Late-term abortions are only used under the most compelling of circumstances—to protect a woman's health or life or because of grave fetal abnormality * * * nearly all abortions are performed in the first trimester.'' PPFA said in a press release that the partial-birth abortion procedure is ''done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality.'' (Nov. 1, 1995)

However, claims such as these are inconsistent with the writings and recorded statements of the three doctors who are most closely identified with the procedure: Dr. Martin Haskell, Dr. James McMahon, and Dr. David Grundmann.

Reasons for Partial-Birth Abortions: Dr. Martin Haskell

In his 1992 paper, Dr. Martin Haskell, who has performed over 1,000 partial-birth abortions, described the procedure as ''a quick, surgical outpatient method that can be performed on a scheduled basis under local anesthesia.'' Dr. Haskell, a family practitioner who operates three abortion clinics, wrote that he ''routinely performs this procedure on all patients 20 through 24 weeks'' (4½ to

5½ months) pregnant, except on women who are more than 20 pounds overweight, have twins, or have certain other complicating factors.

For information on why Dr. Haskell adopted the method, the 1993 interview in Cincinnati Medicine is very instructive. Dr. Haskell explained that he had been performing dismemberment abortions (D&Es) to 24 weeks: But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D&Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have a foot length presentation, you'd reach up and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. * * * Then I said, ''Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it.'' I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

In 1993, the American Medical News—the official newspaper of the AMA—conducted a tape-recorded interview with Dr. Haskell concerning this specific abortion method, in which he said: And I'll be quite frank: most of my abortions are elective in that 20–24 week range. * * * In my particular case, probably 20% [of this procedure] are for genetic reasons. And the other 80% are purely elective.

In a lawsuit in 1995, Dr. Haskell testified that women come to him for partial-birth abortions with ''a variety of conditions. Some medical, some not so medical.'' Among the ''medical'' examples he cited was ''agoraphobia'' (fear of open places). Moreover, in testimony presented to the Senate Judiciary Committee on November 17, 1995, ob/gyn Dr. Nancy Romer of Dayton (the city in which Dr. Haskell operates one of his abortion clinics) testified that three of her own patients had gone to Haskell's clinic for abortions ''well beyond'' 4½ months into pregnancy, and that ''none of these women had any medical illness, and all three had normal fetuses.''

Brenda Pratt Shafer, a registered nurse who observed Dr. Haskell use the procedure to abort three babies in 1993, testified that one little boy had Down Syndrome, while the other two babies were completely normal and their mothers were healthy. [Nurse Shafer's testimony before the House Judiciary subcommittee, with associated documentation, is available on request to NRLC.]

Reasons for Partial-Birth Abortions: Dr. James McMahon

The late Dr. James McMahon performed thousands of partial-birth abortions, including the third-trimester abortions performed on the five women who appeared with President Clinton at his April 10 veto ceremony. Dr. McMahon's general approach is illustrated by this illuminating statement in the July 5, 1993 edition of *American Medical News*: ''[A]fter 20 weeks where it frankly is a child to me, I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.' On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother.''

In June, 1995, Dr. McMahon submitted to Congress a detailed breakdown of a ''series'' of over 2,000 of these abortions that he had performed. He classified only 9% (175 cases) as involving ''maternal [health] indications,'' of which the most common was ''depression.''

Dr. Pamela E. Smith, director of Medical Education, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, Chicago, gave the Senate Judiciary Committee her analysis of Dr. McMahon's 175 ''maternal indication'' cases. Of this sample, 39 cases (22%) were for maternal ''depression,'' while another 16% were ''for conditions consistent with the birth of a normal child (e.g., sickle cell trait, prolapsed uterus, small pelvis),'' Dr. Smith noted. She added that in one-third of the cases, the conditions listed as ''maternal indications'' by Dr. McMahon really indicated that the procedure itself would be seriously risky to the mother.

Of Dr. McMahon's series, another 1,183 cases (about 56%) were for ''fetal flaws,'' but these included a great many non-lethal disorders, such as cleft palate and Down Syndrome. In an op ed piece written for the *Los Angeles Times*, Dr. Katherine Dowling, a family physician at the University of Southern California School of Medicine, examined Dr. McMahon's report on this ''fetal flaws'' group. She wrote: Twenty-four were done for cystic hydroma (a benign lymphatic mass, usually treatable in a child of normal intelligence). Nine were done for cleft lip-palate syndrome (a friend of mine, mother of five, and a colleague who is a pulmonary specialist were born with this problem). Other reasons included cystic fibrosis (my daughter went through high school with a classmate with cystic fibrosis) and duodenal atresia (surgically correctable, but many children with this problem are moderately mentally retarded). Guess they can't enjoy life, can they? In fact, most of the partial-birth abortions in that [McMahon] survey were done for problems that were either surgically correctable or would result in some degree of neurologic or mental impairment, but would not harm the mother. Or they were done for reasons that were pretty skimpy: depression, chicken pox, diabetes, vomiting. [''What Constitutes A Quality Life?,'' *Los Angeles Times*, Aug. 28, 1996]

Over one-third of McMahon's 2,000-abortion ''series'' involved neither fetal nor maternal health problems, however trivial.

In Dr. McMahon's interviews with American Medical News and with Keri Harrison, counsel to the House Judiciary Subcommittee on the Constitution, Dr. McMahon freely acknowledged that he performed late second trimester procedures that were ''elective'' even by his definition (''elective'' meaning without fetal or maternal medical justification).

After 26 weeks, Dr. McMahon claimed that all of his abortions were ''non-elective''—but his definition of ''non-elective'' was very expansive. His written submission stated: ''After 26 weeks [six months], those pregnancies that are not flawed are still non-elective. They are interrupted because of maternal risk, rape, incest, psychiatric or pediatric indications.'' [''Pediatric indications'' was Dr. McMahon's terminology for young teenagers.]

Reasons for Partial-Birth Abortions: Dr. David Grundmann

Dr. David Grundmann, the medical director for Planned Parenthood of Australia, has written a paper in which he explicitly states that he uses the partial-birth abortion procedure (he calls it ''dilatation and extraction'') as his ''method of choice'' for abortions done after 20 weeks (4½ months), and that he performs such abortions for a broad variety of social reasons. [This paper, ''Abortion After Twenty Weeks in Clinical Practice: Practical, Ethical and Legal Issues,'' and associated documentation, is available from NRLC.]

Dr. Grundmann himself described the procedure in a television interview as ''essentially a breech delivery where the fetus is delivered feet first and then when the head of the fetus is brought down into the top of the cervical canal, it is decompressed with a puncturing instrument so that it fits through the cervical opening.''

In the 1994 paper, Dr. Grundmann listed several ''advantages'' of this method, such as that it ''can be performed under local and/or twi-light anesthetic'' with ''no need for narcotic analgesics,'' ''can be performed as an ambulatory out-patient procedure,'' and there is ''no chance of delivering a live fetus.'' Among the ''disadvantages,'' Dr. Grundmann wrote, is ''the aesthetics of the procedure are difficult for some people; and therefore it may be difficult to get staff.'' (Dr. Grundmann also wrote that ''abortion is an integral part of family planning. Theoretically this means abortions at any stage of gestation. Therefore I favor the availability of abortion beyond 20 weeks.'')

Dr. Grundmann wrote that in Australia, late-second-trimester abortion is available ''in many major hospitals, in most capital cities and large provincial centres'' in case of ''lethal fetal abnormalities'' or ''gross fetal abnormalities,'' or ''risk to maternal life,'' including ''psychotic/suicidal behavior.'' However, Dr. Grundmann said, his Planned Parenthood clinic also offers the procedure after 20 weeks for women who fall into five additional ''categories'': (1) ''minor or doubtful fetal abnormalities,'' (2) ''extreme maternal immaturity i.e. girls in the 11 to 14 year age group,'' (3) women ''who do not know they are pregnant,'' for example because of amenorrhea [irregular menstruation] ''in women who are very active such as athletes of those under extreme forms of stress i.e. exam stress, relationship breakup * * *,'' (4) ''intellectually impaired women, who are unaware of basic biology * * *,'' (5) ''major life crises or major changes in socio-economic circumstances. The most common example of this is a planned or wanted pregnancy followed by the sudden death or desertion of the partner who is in all probability the bread winner.''

IS A PARTIAL-BIRTH ABORTION EVER THE ONLY WAY TO PRESERVE A MOTHER'S PHYSICAL HEALTH?

President Clinton and pro-abortion advocacy groups have made strenuous efforts to persuade the public that partial-birth abortions are necessary to protect the lives or health of pregnant women, and many journalists have uncritically accepted this claim at face value. However, these claims are coming under increasingly sharp challenge from prestigious medical experts, and from women who have given birth to babies in circumstances such as those cited by President Clinton.

The sort of cases highlighted by President Clinton third-trimester abortions of babies with disorders incompatible with sustained life outside the womb—account for a small fraction of all the partial-birth abortions. Confronted with identical cases, most specialists would never consider executing a breech extraction and puncturing the skull. Instead, most would deliver the baby alive, sometimes early, without jeopardy to the mother—usually viginally—and make the baby as comfortable as possible for whatever time the child has allotted to her.

In an interview published in the August 19 edition of American Medical News, former Surgeon General C. Everett Koop said, ''I believe that Mr. Clinton was misled by his medical advisors on what is fact and what is fiction in reference to late-term abortions. Because in no way can I twist my mind to see that the later-term abortions as described—you know, partial birth, and then destruction of the unborn child before the head is born—is a medical necessity for the mother. It certainly can't be a necessity for the baby.''

Dr. Koop, a world-renown pediatric surgeon, was asked by the American Medical

News reporters whether he had ever ''treated children with any of the disabilities cited in this debate? For example, have you operated on children born with organs outside of their bodies?'' Dr. Koop replied, ''Oh, yes indeed. I've done that many times. The prognosis usually is good. There are two common ways that children are born with organs outside of their body. One is an omphalocele, where the organs are out but sill contained in the sac * * * the first child I ever did, with a hug omphalocele much bigger than her head, went on to develop well and become the head nurse in my intensive care until many years later.''

In addition, in the summer of 1996, an organization called Physicians' Ad Hoc Coalition for Truth (PHACT) began circulating material directly challenging President Clinton's claims. As of early September, PHACT reportedly consisted of over 230 physicians, mostly professors and other specialists in obstetrics, gynecology, and fetal medicine. In an advertisement published in August, the PHACT physicians said: Congress, the public—but most importantly women—need to know that partial-birth abortion is never medically indicated to protect a mother's health or her future fertility.

The PHACT doctors also referred directly to the specific medical conditions that affected some of the women who appeared with President Clinton at his April 10 veto ceremony, such as hydrocephalus (excessive fluid in the head), and commented: We, and many other doctors across the United States, regularly treat women whose unborn children suffer these and other serious conditions. Never is the partial-birth procedure medically indicated. Rather, such infants are regularly and safely delivered live, vaginally, with no threat to the mother's health or fertility.

At a July 24 briefing on Capitol Hill, PHACT member Dr. Curtis Cook, and ob/gyn perinatologist with the West Michigan Perinatal and Genetic Diagnostic Center (616–391–3681), said that partial-birth abortion is never necessary to preserve the life or the fertility of the mother, and may in fact threaten her health or well-being or future fertility. In my practice, I see these rare, unusual cases that come to most generalists' offices once in a lifetime—they all come into our office. We see these every day * * * The presence of fetal disabilities or fetal anomalies are not a reason to have a termination of pregnancy to preserve the life of the mother—they do not threaten the life of the mother in any way * * * [and] where these rare instances do occur, they do not require the death of the baby or the fetus prior to the completion of the delivery.

Also present at the July 24 briefing were several women who, while pregnant, had learned that their unborn babies were afflicted with conditions similar or identical to those cited by President Clinton, but who gave birth to their babies alive. One of the women, Jeannie French of Oak Park, Illinois, distributed a July 17 letter that she and several other women sent to President Clinton, asking for a meeting so that he could learn about the medical alternatives to partial-birth abortion. Ms. French wrote: In recent months, I have had the opportunity to get to know many women who've carried and given birth to children with fatal conditions from anacephaly, encepaloceles, Trisomy 18, hydrocephaly, and even a rare disease called body stalk anomaly, in which internal organs develop outside a baby's body. We gave birth to our children knowing that their serious physical disabilities might not allow them to live long. * * * You say that partial-birth abortion has to be legal for cases like ours, because women's bodies would be 'ripped to shreds' by carrying their very sick children to term. By your repeated statements, you imply that partial-birth abortion is the only or the most desirable response to children suffering severe disabilities like our children. * * * This message is so wrong! * * * Will you meet with us personally, and hear our stories?

Ms. French got a brief letter of response from two White House scheduling aides, who said that ''the tremendous demands on the President will not give him the opportunity to speak with you and your group. * * * Your continued interest and support are deeply appreciated.''

WHAT ABOUT PRESIDENT CLINTON'S STATEMENT THAT FOR SOME WOMEN, THE ONLY ALTERNATIVE TO PARTIAL-BIRTH ABORTION IS TO ''RIP YOUR BODY TO SHREDS''?

President Clinton has repeatedly justified his veto by referring to cases in which the baby suffers from advanced hydrocephaly (head enlargement). Speaking in Milwaukee on May 23, President Clinton suggested that Bob Dole or others who would deny a partial-birth abortion in such cases are saying ''it's okay with me if they ripped your body to shreds and you could never have another baby.''

But this is medical nonsense. Medical specialists commonly deal with cases of severe hydrocephaly by a procedure called cephalocentesis, in which a needle is used to withdraw the excess fluid (but not the brain), reducing the head size so that normal delivery of a live baby can occur. An eminent authority on such matters, Dr. Watson A. Bowes, Jr., professor of ob/gyn (maternal and fetal medicine) at the University of North Carolina, who is co-editor of the Obstetrical and Gynecological Survey, wrote to Congressman Charles Canady: Critics of your bill who say that this legislation will prevent doctors from performing certain procedures which are standard of care, such as cephalocentesis (removal of fluid from the enlarged head of a fetus with the most severe form of hydrocephalus) are mistaken. In such a procedure a needle is inserted with ultrasound guidance through the mother's abdomen into the uterus and then into the enlarged ventricle of the brain (the space containing cerebrospinal fluid). Fluid is then withdrawn which results in reduction of the size of the head so that delivery can occur. This procedure is not intended to kill the fetus, and, in fact, is usually associated with the birth of a live infant.

(Note: Cases of hydrocephaly accounted for less than 4% of Dr. McMahon's partial-birth abortions, according to his submission to the House Judiciary Committee.)

WHAT ABOUT THE SMALL MINORITY OF CASES THAT DO INVOLVE ''SERIOUS FETAL DEFORMITY''?

It is true that some partial-birth abortions—a small minority—involve babies who have grave disorders that will result in death soon after birth. But these unfortunate members of the human family deserve compassion and the best comfort-care that medical science can offer—not a scissors in the back of the head. In some such situations there are good medical reasons to deliver such a child early, after which natural death will follow quickly.

Dr. Harlan Giles, a professor of ''high-risk'' obstetrics and perinatology at the Medical College of Pennsylvania, performs abortions by a variety of procedures up until ''viability.'' However, in sworn testimony in the U.S. Federal District Court for the Southern District of Ohio (Nov. 13, 1995), Prof. Giles said: [After 23 weeks] I do not think there are any maternal conditions that I'm aware of that mandate ending the pregnancy that also require that the fetus be dead or that the fetal life be terminated. In my experience for 20 years, one can deliver these fetuses either vaginally, or by Cesarean section for that matter, depending on the choice of the parents with informed consent. * * * But there's no reason these fetuses cannot be delivered intact vaginally after a miniature labor, if you will, and be at least assessed at birth and given the benefit of the doubt. [transcript, page 240]

In a partial-birth abortion, the abortionist dilates a woman's cervix for three days, until it is open enough to deliver the entire baby breech, except for the head. When American Medical News asked Dr. Martin Haskell why he could not simply dilate the woman a little more and remove the baby without killing him, Dr. Haskell responded: The point here is you're attempting to do an abortion * * * not to see how do I manipulate the situation so that I get a live birth instead. [American Medical News transcript]

Under closer examination, it becomes clear that in some cases, the primary reason for performing the procedure is not concern that the baby will die in utero, but rather, that he/she will be born alive, either with disorders incompatible with sustained life outside the womb, or with a non-lethal disability. (Again, in Dr. McMahon's table of partial-birth abortions performed for ''fetal indications,'' the largest category was for Down Syndrome.)

Viki Wilson, whose daughter Abigail died at the hands of Dr. McMahon at 38 weeks, said: I knew that I could go ahead and carry the baby until full term, but knowing, you know, that this was futile, you know, that she was going to die * * * I felt like I needed to be a little more in control in terms of her life and my life, instead of just sort of leaving it up to nature, because look where nature had gotten me up to this point. [NAF video transcript, page 4.]

Tammy Watts, whose baby was aborted by Dr. McMahon in the 7th month, said: I had a choice. I could have carried this pregnancy to term, knowing everything that was wrong. [Testimony before Senate Judiciary Committee, Nov. 17, 1995]

Claudia Crown Ades, who appeared with President Clinton at the April 10 veto, said: My procedure was elective. That is considered an elective procedure, as were the procedures of Coreen Costello and Tammy Watts and Mary Dorothy-Line and all the other women who were at the White House yesterday. All of our procedures were considered elective. [Quotes from taped appearance on WNTM, April 12, 1996]

In a letter opposing HR 1833, one of Dr. McMahon's colleagues at Cedar-Sinai Medical Center, Dr. Jeffrey S. Greenspoon, wrote: As a volunteer speaker to the National Spina Bifida Association of America and the Canadian National Spina Bifida Organization, I am familiar with the burden of raising a significantly handicapped child * * * The burden of raising one or two abnormal children is realistically unbearable. [Letter to Rep. Hyde, July 19, 1995]

IS THERE A MORE ''OBJECTIVE'' TERM FOR THE PROCEDURE THAN ''PARTIAL-BIRTH ABORTION?

Some opponents of the Partial-Birth Abortion Ban Act (HR 1833) insist that anyone writing about the bill should say that it bans a procedure ''known medically as intact dilation and evacuation.'' But when journalists comply with this demand, they do so at the expense of accuracy. The bill itself makes no reference whatever to ''intact dilation and evacuation'' abortions. More importantly, the term ''intact dilation and evacuation'' is not equivalent to the class of procedures banned by the bill.

The bill would make it a criminal offense (except to save woman's life) to perform a ''partial-birth abortion,'' which the bill

would define—as a matter of law—as ''an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.''

In contrast, the term ''intact dilation and evacuation'' was invented by the late Dr. James McMahon, and until recently, was idiosyncratic to him. It appeared in no standard medical textbook or database, nor anywhere in the standard textbook on abortion methods, Abortion Practice by Dr. Warren Hern. Because ''intact dilation and evacuation''[2] is not a standard, clearly defined medical term, the House Judiciary Constitution Subcommittee staff (which drafted the bill under Congressman Canady's supervision) rejected it as useless for purposes of defining a criminal offense. Indeed, it is worse than useless—a criminal statute that relied on such a term would be stricken by the federal courts as ''void for vagueness.''

Although there is no clear definition of the term, we know enough to say that it is inaccurate to equate ''intact dilation and evacuation'' abortions with the procedures banned by HR 1833, since in his writings Dr. McMahon clearly used the term ''intact dilation and evacuation'' so broadly as to cover certain procedures which would not be affected at all by HR 1833 (e.g., removal of babies who are killed entirely in utero, and removal of babies who have died entirely natural deaths in utero). Indeed, at least one of the specific women highlighted by opponents of HR 1833 had various types of ''intact D&E'' abortion procedures that were not covered by HR 1833's definition of ''partial-birth abortion.''

[In his 1992 instructional paper, Dr. Haskell referred to the method as ''dilation and extraction'' or ''D&X''—noting that he ''coined the term.'' When the bill was drafted, the term ''dilation and extraction'' did not appear in medical dictionaries or databases.]

The term chosen by Congress, partial-birth abortion, is in no sense misleading. In sworn testimony in an Ohio lawsuit on Nov. 8, 1995, Dr. Martin Haskell—who has done over 1,000 partial-birth abortions, and who authored the instructional paper that touched off the controversy over the procedure—explained that he first learned of the method when a colleague described very briefly over the phone to me a technique that I later learned came from Dr. McMahon where they internally grab the fetus and rotate it and accomplish—be somewhat equivalent to a breech type of delivery.

ARE THE FIVE LINE DRAWINGS OF THE PROCEDURE CIRCULATED BY NRLC ACCURATE, OR MISLEADING?

The AMA newspaper American Medical News (July 5, 1993) interviewed Dr. Martin Haskell and reported: Dr. Haskell said the drawings were accurate ''from a technical point of view.'' But he took issue with the implication that the fetuses were ''aware and resisting.''

Professor Watson Bowes of the University of North Carolina at Chapel Hill, co-editor of the Obstetrical and Gynecological Survey, wrote in a letter to Congressman Canady: Having read Dr. Haskell's paper, I can assure you that these drawings accurately represent the procedure described therein. * * * Firsthand renditions by a professional medical illustrator, or photographs or a video recording of the procedure would no doubt be more vivid, but not necessarily more instructive for a non-medical person who is trying to understand how the procedure is performed.

On Nov. 1, 1995, Congresswoman Patricia Schroeder and her allies actually tried to prevent Congressman Canady from displaying the line drawings during the debate on HR 1833 on the floor of the House of Representatives. But the House voted by nearly a 4-to-1 margin (332 to 86) to permit the drawings to be used.

DOES THE BILL CONTRADICT U.S. SUPREME COURT DECISIONS?

The Supreme Court has never said that there is a constitutional right to kill human beings who are mostly born.

In its official report on HR 1833, the House Judiciary Committee makes the very plausible argument that HR 1833 could be upheld by the Supreme Court without disturbing Roe. In Roe, the Supreme Court said that ''the word 'person,' as used in the Fourteenth Amendment, does not include the unborn.'' Thus, under the Supreme Court's doctrine, a human being becomes a legal ''person'' upon emerging from the uterus. But a partial-birth abortion does not involve an ''unborn fetus.'' A partial-birth abortion, by the very definition in the bill, kills a human being who is partly born. Indeed, a partial-birth abortion kills a human being who is four-fifths across the 'line-of-personhood' established by the Supreme Court.

Moreover, in Roe v. Wade itself, the Supreme Court took note of a Texas law that made it a felony to kill a baby ''in a state of being born and before actual birth,'' and the Court did not disturb that law.

Thus, the Supreme Court could very well decide that the killing of a mostly born baby, even if done by a physician, is not protected by Roe v. Wade.

THE PARTIAL-BIRTH ABORTION BAN ACT (H.R. 1833) AS PASSED BY THE U.S. SENATE ON DECEMBER 7, 1995 AND BY THE U.S. HOUSE OF REPRESENTATIVES ON MARCH 27, 1996

Section 1. Short Title.

This Act may be cited as the ''Partial-Birth Abortion Ban Act of 1995.''

Sec. 2. Prohibition on Partial-Birth Abortions

(a) In General.—Title 18, United States Code, is amended by inserting after Chapter 73 the following: ''Chapter 74—Partial-Birth Abortions.

Sec. 1531. Partial-birth abortions prohibited.

(a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than two years, or both. This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury: Provided, That no other medical procedure would suffice for that purpose. This paragraph shall become effective one day after enactment.

(b)(1) As used in this section, the term 'partial-birth abortion' means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

(2) As used in this section, the term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, That any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

(c)(1) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

(2) Such relief shall include—

(A) money damages for all injuries, psychological and physical, occasioned by the violation of this section; and

(B) statutory damages equal to three times the cost of the partial-birth abortion.

(d) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section, for a conspiracy to violate this section, or for an offense under section 2, 3, or 4 of this title based on a violation of this section.

STEP 5

''[T]he surgeon then forces the scissors into the base of the skull * * * [H]e spreads the scissors to enlarge the opening. The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.'' Text from Martin Haskell, M.D., Dilation and Extraction for Late Second Trimester Abortion.

TRIBUTE TO ANTONIO BROWN

HON. JACK KINGSTON

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 26, 1996

Mr. KINGSTON. Mr. Speaker, I submit for the RECORD a story of a true hero. It is fitting and proper for Congress to recognize Mr. Antonio Brown for his gallant effort. We need more citizens like him.

[From the Savannah Morning News, June 28, 1996]

MAN SHOT TRYING TO THWART ARMED ROBBERY

(By John Cheves and Keith Paul)

Antonio L. Brown wasn't going to stand quietly and watch a mugging.

Not on his street. Not when the victim was a friend.

Instead, Brown was shot in the head at about 11 p.m. Wednesday after he attempted to thwart the armed robbery on the 600 block of East Duffy Street, just a stone's throw from his family's home.

He remained in critical condition Thursday night at Memorial Medical Center.

The 21-year-old Savannah High School graduate was standing in his small front yard late Wednesday, relatives said. When Brown looked west down Duffy Street, he saw the attempted mugging of a male friend.

''He said, 'I just can't let that happen like that,' and then he walked over there,'' said nephew Rajai Steward on Thursday.

Added Savannah police Detective Deborah A. Robinson, ''Brown stepped in between the two to stop the robbery. He was trying to fight with the assailant and was shot once in the head.''

Police searched Thursday for the suspected gunman, Jarrett Myers, 20, of 413 E. Waldburg St. Police filed warrants charging Myers with aggravated assault.

Brown knew Myers casually, but the two weren't friends, Brown's family said.

[2] The term ''intact dilation and evacuation'' should not be confused with ''dilation and evacuation,'' which is a procedure commonly sued in second-trimester abortions, involving dismemberment of the fetus/baby while still in the uterus. The bill does not apply to ''dilation and evacuation'' abortions at all.